Backgrounder: *Access to Health Care Services in Canada, 2001*

Report issued by Statistics Canada, July 15, 2002

This backgrounder discusses the currently available provincial data for PEI: a) waiting times for key treatment and diagnostic services; b)access to 24/7 first contact health services and; c) unmet health needs. The other data released on July 15th will include Canadian results, not broken down by province, such as reasons for unmet health needs and barriers to accessing health care and services. This information is available in chart and table form on CANSIM (Statistics Canada web site) as well as in the report entitled, "Access to Health Care Services in Canada, 2001".

BACKGROUND

The Health Services Access Survey is a special household survey and a supplement to the Canadian Community Health Survey (CCHS), which was conducted by Statistics Canada in November 2001. It was developed and conducted to collect initial data on: a) waiting time for key treatment and diagnostic services, and b) access to 24/7 first contact health services for the Performance Indicator Reporting Committee (PIRC) report on 14 health status, health outcomes and service quality outcomes to be released by each province and territory beginning in September 2002. This report is a mechanism for public reporting and accountability as required by the First Ministers agreement called Communique on Health, September, 2000.

Wait times was selected as a key service quality indicator by PIRC because health care systems have a role in achieving reasonable wait times for services by ensuring effective management of wait lists and operating room schedules, effective bed utilization strategies, and appropriate budget allocation for prevention, treatment and follow-up care. Access to 24/7 first contact services was selected as another service quality indicator because the ability to obtain these services when needed is believed to be important in maintaining health, preventing more serious health problems and encouraging appropriate use of and preventing the inappropriate use of services (e.g., use of hospital emergency rooms for non-emergencies).

Three provinces paid to participate in the survey with representative sample sizes : PEI, Alberta, and B.C. Data was collected from the other jurisdictions provinces with smaller samples for the purposes of comparison. The sample sizes for each province and for Canada are in Table 1.

Table 1. Health Services Access Survey sample size and response rates, by province

	NF	PEI	NS	NB	QC	ON	MB	SK	AB	BC	Canada
Sample size	1,000	1,259	1,000	1,000	1,250	1,400	1,000	1,000	3,868	4,839	17,616
Response Rate	77.3%	80.4%	85.4%	80.0%	82.4%	78.5%	79.9%	83.3%	79.8%	81.1%	80.7%

The survey did not include persons under 15 years old, persons living on First Nations Reserves or Crown lands, residents of institutions, full- time members of the Canadian Armed Forces and residents of certain remote regions.

Backgrounder: ***Access to Health Care Services in Canada, 2001***

Report issued by Statistics Canada, July 15, 2002

This backgrounder discusses the currently available provincial data for PEI: a) waiting times for key treatment and diagnostic services; b)access to 24/7 first contact health services and; c) unmet health needs. The other data released on July 15th will include Canadian results, not broken down by province, such as reasons for unmet health needs and barriers to accessing health care and services. This information is available in chart and table form on CANSIM (Statistics Canada web site) as well as in the report entitled, "Access to Health Care Services in Canada, 2001".

BACKGROUND

The Health Services Access Survey is a special household survey and a supplement to the Canadian Community Health Survey (CCHS), which was conducted by Statistics Canada in November 2001. It was developed and conducted to collect initial data on: a) waiting time for key treatment and diagnostic services, and b) access to 24/7 first contact health services for the Performance Indicator Reporting Committee (PIRC) report on 14 health status, health outcomes and service quality outcomes to be released by each province and territory beginning in September 2002. This report is a mechanism for public reporting and accountability as required by the First Ministers agreement called Communique on Health, September, 2000.

Wait times was selected as a key service quality indicator by PIRC because health care systems have a role in achieving reasonable wait times for services by ensuring effective management of wait lists and operating room schedules, effective bed utilization strategies, and appropriate budget allocation for prevention, treatment and follow-up care. Access to 24/7 first contact services was selected as another service quality indicator because the ability to obtain these services when needed is believed to be important in maintaining health, preventing more serious health problems and encouraging appropriate use of and preventing the inappropriate use of services (e.g., use of hospital emergency rooms for non-emergencies).

Three provinces paid to participate in the survey with representative sample sizes : PEI, Alberta, and B.C. Data was collected from the other jurisdictions provinces with smaller samples for the purposes of comparison. The sample sizes for each province and for Canada are in Table 1.

Table 1. Health Services Access Survey sample size and response rates, by province

	NF	PEI	NS	NB	QC	ON	MB	SK	AB	BC	Canada
Sample size	1,000	1,259	1,000	1,000	1,250	1,400	1,000	1,000	3,868	4,839	17,616
Response Rate	77.3%	80.4%	85.4%	80.0%	82.4%	78.5%	79.9%	83.3%	79.8%	81.1%	80.7%

The survey did not include persons under 15 years old, persons living on First Nations Reserves or Crown lands, residents of institutions, full- time members of the Canadian Armed Forces and residents of certain remote regions.

ISSUE

The wait time and 24/7 access indicators reflect several aspects of health service quality, for instance appropriateness, effectiveness, accessibility and acceptability of services. These indicators do not address all dimensions of service quality such as efficiency and safety.

1. Waiting times for key treatment and diagnostic services

Self-reported wait times are reported on the following indicators:
(a) specialist physician visits (include visits for a new illness or condition only)
(b) diagnostic services (include non-emergency MRIs, CT Scans and angiographies only)
(c) surgery (includes only non-emergency cases)

a) Self-reported median wait time

Median wait time refers to the length of time, in weeks, between the patient being referred for a specialized service and actually receiving the service, during the 12 months prior to the survey as reported by the people who were surveyed. The median is the middle wait time where half the patients waited less and half wait longer. Median measure was used because it is less sensitive to wide distributions in responses and hence a more accurate indication of central tendency than the average measure.

Figure 1 Self-reported median waiting times for specialist visits, non-emergency surgeries and diagnostic tests, population age 15+ Canada and PEI, 2001

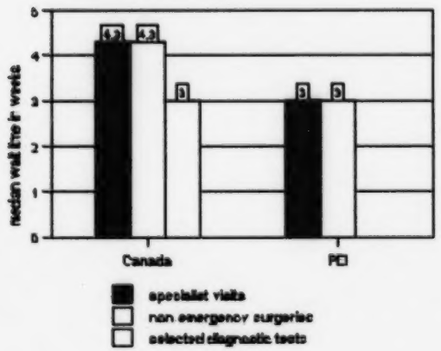


Figure 1 shows that PEI has a shorter reported median wait time for specialist physician visits and non-emergency surgery than the Canadian average by 1.3 weeks. In fact, PEI has the shortest median wait time of any province or territory across the country. Unfortunately PEI did not have a large enough sample size to produce results for median wait times for selected diagnostic tests.

b) Distribution of self-reported wait times

The distribution of self-reported wait time refers to the length of time, in weeks, between the patient being referred for a specialized service and actually receiving the service, during the 12 months prior to the survey as reported by the people who were surveyed. It is divided into three categories ie; to the percent of those requiring a specialized health service that waited less than 1 month, between 1 to 3 months, or more than 3 months.

Figure 2 Distribution of self-reported waiting times for specialist visits by length of wait time Canada and PEI, 2001

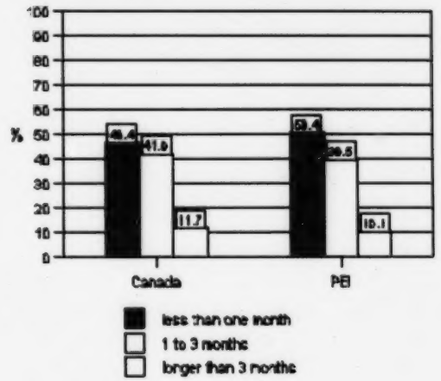


Figure 2 shows that about half of the Islanders who waited for specialist physician services reported that they waited for less than a month. This rate was slightly higher than the Canadian average of 46.4%. Only about 10% of both Islanders and Canadians who waited for specialist physician services reported waiting for more than 3 months.

Figure 3 shows that 58% of the Islanders who waited for non-emergency surgery reported that they waited for less than one month which is much higher than the Canadian rate of 39.5 % who reported waiting for less than one month. Unfortunately PEI did not have a large enough sample size to produce results for median wait times for longer than 3 months.

Table 3 Distribution of waiting times for non-emergency surgeries by length of wait time Canada and PEI, 2001

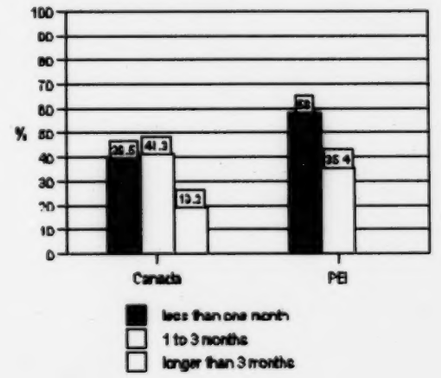
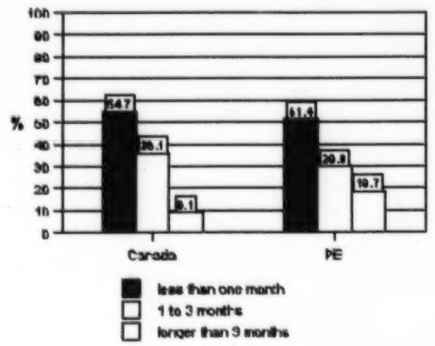


Figure 4 shows that about half of the Islanders and of Canadians as a whole who waited for diagnostic tests reported that they waited for less than a month. Diagnostic tests include non-emergency MRIs, CT Scans and angiographies only. About twice as many Islanders (18%) than Canadians as a whole (9.1%) reported waiting for more than 3 months.

Figure 4 Distribution of self-reported waiting times for diagnostic tests by length of wait time Canada and PEI, 2001



2. Access to 24/7 first contact health services

Access to 24/7 first contact health services refers to four kinds of service:
a) routine or on-going health services
b) health information or advice
c) immediate care for a minor health problem and/or
d) family physicians

The following indicators are the percent of surveyed individuals who experienced difficulty obtaining those services. Difficulty obtaining services refers to the percent of people who required those services for self or a family member in the 12 months prior to the survey and experienced difficulties obtaining them (a) during regular daytime hours (9am to 5pm, Monday to Friday) or (b) during evenings (5pm to 9 pm Monday to Friday) or weekends (Saturday and Sunday).

a) Difficulty obtaining routine or on-going health services

Figure 5 Percentage of population reporting difficulties accessing routine or on-going care, by time of day Canada and PEI, 2001

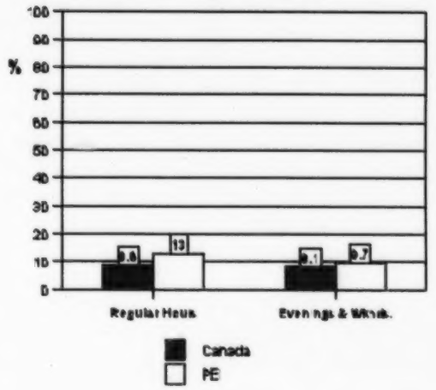


Figure 5 shows that very few Islanders reported having difficulty accessing routine or on-going care. Only 13 % had difficulties during regular daytime hours and only 9.7% had difficulties during evenings and weekends. These rates are only slightly higher than the national average.

b) Difficulty obtaining health information or advice

Access to information or advice is believed to be important to maintaining health and ensuring appropriate access to health services.

Figure 6 Percentage of population reporting difficulties obtaining health information or advice, by time of day Canada and PEI, 2001

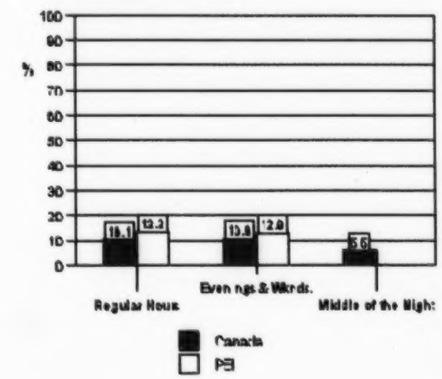


Figure 6 shows that few Islanders reported having difficulty obtaining health information or advice. Only 13.2 % had difficulties during regular daytime hours and only 12.9% had difficulties during evenings and weekends. These rates are only slightly higher than the national average. Unfortunately PEI did not have a large enough sample size to produce results for difficulties obtaining health information or advice in the middle of the night..

In interpreting these results, it is important to note that "health information" and "advice" are distinct items. In the Access Survey, these two items are reported together. Where and how an individual accesses health information and advice can be quite different. For example, In PEI, the Health Information Resource Centre (HIRC) is mandated to provide health information but not advice.

Depending on how the term information is defined, it can mean a variety of things such as health promotion, disease management or referral information. The interpretation and/or prior experience of the survey respondents would influence their response to the survey questions on access to health information or advice.

c) Difficulty obtaining immediate care

Minor health problems are those that are not emergencies. The ability to obtain immediate needed care for minor health problems is believed to be important in restoring health, preventing health emergencies, and preventing the inappropriate use of services (e.g., use of hospital emergency rooms for non-emergencies).

Figure 7 Percentage of population reporting difficulties obtaining immediate care for a minor health problem, by time of day Canada and PEI, 2001

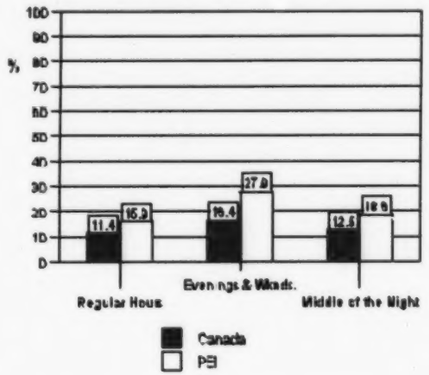


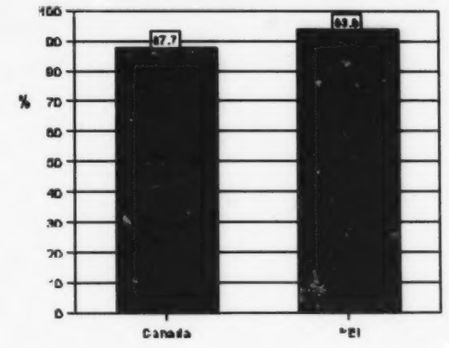
Figure 7 shows that more Islanders reported having difficulty obtaining immediate care for a minor health problem , with 15.9% having difficulties during regular daytime hours, 27.9% during evenings and weekends and 18.6% in the middle of the night. These rates are higher than the national average.

d) Percent having a regular family doctor

Establishing an on-going relationship with a family doctor is believed to be important in maintaining health and ensuring appropriate access to health services.

Figure 8 shows that the percentage of the population who reported that they have a family doctor in 2001 was 93.6% for PEI. This is higher than the national rate of 87.7% for Canada.

Figure 8 Percentage of population (age 15+) who have a regular family doctor Canada and PEI, 2001



e) Reasons for not having a family physician

In addition to determining whether survey respondents had a regular family physician, respondents who did not have one, were asked for the reason. The majority of respondents across Canada (62.6%) indicated that they did not try to contact one. For PEI, this rate was much lower at around 18%. The other main reason for not having a regular family physician was physician availability reported by 28% of respondents across Canada compared to over 70% of PEI respondents. Physician availability was also most often cited by respondents throughout Atlantic Canada.

f) Quality of family physician care reported by those with a regular family physician

Figure 9 Percent of population with a regular family physician reporting on quality of family physician by level of qualityCanada and PEI, 2001

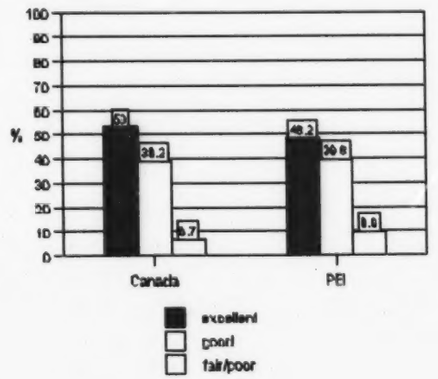


Figure 9 Close to 90% of PEI respondents that have a regular family physician, rate the level of care as excellent or good. This is very close to the national average.

3. Unmet Health Care Needs

a) Percentage of population reporting unmet health care needs by type of service

Figure 10 Percent of population reporting unmet helath care needs by type of service Canada and PEI, 2001

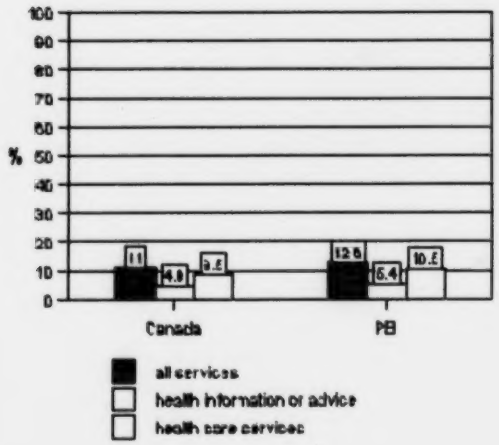


Figure 10 Like Canada as a whole very few Islanders report having unmet health care needs. More did express concern about unmet needs regarding health care services as compared to health information or advice.

Prince Edward Island
Highlights

Second Report on the Health of Canadians

September 1999

Prepared by Dr. L. VanTil, H. MacMillan, Department of Health and Social Services,
Epidemiology Unit, Charlottetown, P.E.I., September 1999

Printed by the Document Publishing Centre, Queens Printing, Charlottetown, P.E.I., 1999.

Permission is granted for non-commercial reproduction related to educational or service planning purposes, provided there is clear acknowledgement of the source.

Additional copies of this report may be obtained from:
Island Information Services
Communications Division
Department of Provincial Treasury
P.O. Box 2000
Charlottetown, PE
C1A 7N8
(902) 368-4000 or 1-800-236-5196 (toll free in Prince Edward Island).

TABLE OF CONTENTS

Introduction 1
Population Health Approach 1
Disparity by gender, age, socioeconomic status 2
Vision for the future 3
HEALTH STATUS 4
- Demographics
- Death
- Self-rated Health
- Positive Mental Health
- Body Weight
- Chronic Conditions

1. LIVING AND WORKING CONDITIONS 6
- Income
- Unemployment Rate
- Education
- Social Support

2. PHYSICAL ENVIRONMENT 7
- Air pollution
- Environmental Tobacco Smoke
- Smoking Restriction Policies
- Food and Waterborne Diseases
- Sun Exposure

3. DEVELOPMENT, HEALTH CHOICES, INDEPENDENCE 8
- Underweight Births
- Breast-feeding
- Smoking
- Problem Drinking
- Physical Activity
- Seatbelt Use
- Long-term Activity Limitation

4. HEALTH SERVICES 11
- Health Expenditures
- Hospitalization
- Physician Visits
- Emergency Visits
- Psychiatric Hospitalization
- Unmet Health Needs
- Flu Vaccine
- Pap Smears
- Screening Mammogram
- Blood Pressure

5. PREVENTABLE ILLNESS 14
- Vaccine Preventable Diseases
- Cardiovascular Death
- Lung Cancer Death
- Breast Cancer Death
- Hospitalization due to Trauma
- Cervical Cancer Incidence
- Sexually Transmitted Diseases

Summary 17
Sources 18

Introduction

This report contains PEI highlights from the 1999 report: "*Toward a Healthy Future: Second Report on the Health of Canadians*". The *Report on the Health of Canadians* details many measures of health and health determinants. Comments on the nation's health are based on the most current information available. It is a tool to alert policy makers, practitioners and the public to current and future challenges in health.

Health is complex and multifaceted - indicators or measures of health attempt to give only a partial description. Many important topics are not covered. Some of these are water quality, immune status, crime, multiple risks, community-based health services, and quality of health services. The indicators that are available are an imperfect measure of just one dimension of health. These indicators are put into context over time and with provincial comparisons. Each indicator is a summary that describes an overall trend. This means that indicators can mask many differences among subgroups and generate more questions than answers. We expect the discussion of indicators will lead to a better understanding of health.

Population Health Approach

The 1999 *Report on the Health of Canadians* is an important tool for understanding a population health approach, where health is defined as a complete state of physical, mental, social and emotional well-being.

The health of a population is measured by health status indicators and influenced by various determinants: social, economic and physical environments; personal health practices; individual capacity and coping skills; human biology; early childhood development; and health services.

Population health focuses on the interrelated conditions and factors that influence the health of populations. Health care is only one determinant; other determinants are beyond the scope of the health care sector.

Disparity by gender, age, socioeconomic status

Canada ranks in the top three developed countries in the world in measures of life expectancy, self-rated health, and mortality rates. But the high standard of health is not shared by all; there are major disparities between genders, age groups, and levels of socioeconomic status.

Women continue to live longer than men. This is due in part to two of the major causes of premature death among men - ischemic heart disease and lung cancer. Cancer death rates have remained stubbornly persistent for women, mainly due to continuing increases in lung cancer mortality. At the same time, smoking rates among young women have continued to escalate. Now adolescent women are more likely to smoke than adolescent men. Unless the trend toward increased smoking among women is quickly reversed, lung cancer will increasingly become a major killer of women.

When optimal conditions for a child's development are provided, the child experiences positive outcomes for a lifetime. With nurturing and consistent support in later years, many children can overcome early disadvantages. Generally speaking, prevention has the most dramatic benefits earlier in life.

As we age, there is a normal and gradual decline in vision, strength, and other functions. These functions do not all decline at the same rate, and there is marked variation from person to person. We do not know how much of the decline associated with aging is attributable to biological aging, and how much is the result of other factors, such as socioeconomic status, social support, the physical environment, and personal health practices.

Many factors in the social and economic environments affect health, including income and income distribution, education and literacy, employment and unemployment, working conditions and the social environment. Canadians with low incomes and low levels of education (which are often related) are more likely to have poor health status, no matter which measure of health is used. They are also more likely to die earlier than other Canadians, no matter which cause of death is considered.

The United Nations report on human development suggests that efforts to reduce relative poverty, and to increase opportunities in education, employment, wages and participation in political and economic spheres are key strategies for reducing inequities and therefore improving the health and well-being of Canadians.

Vision for the Future

Maintaining and improving health will require a collaborative effort. The means to accomplish this have been articulated by the Advisory Committee on Population Health as found in the *Report on the Health of Canadians*. They recommend the following strategic directions:

- Ensure positive and supportive living and working conditions in our communities.
- Ensure a safe, high quality physical environment.
- Ensure individuals have opportunities for healthy development, and supports for individual choices that enhance health and foster independence.
- Ensure appropriate and affordable health services accessible to all.
- Reduce preventable illness, injury and premature death.

The following sections of this report detail indicators of health status and health determinants. They are organized into topics that start with general indicators of health status, and then are followed by the five topics described above: living and working conditions; physical environment; development, health choices, independence; health services; preventable disease.

M121

IMPORTANT NOTE CONCERNING THE FOLLOWING PAGES

THE PAGES WHICH FOLLOW HAVE BEEN FILMED TWICE IN ORDER TO OBTAIN THE BEST REPRODUCTIVE QUALITY

USERS SHOULD CONSULT ALL THE PAGES REPRODUCED ON THE FICHE IN ORDER TO OBTAIN A COMPLETE READING OF THE TEXT.

REMARQUE IMPORTANTE CONCERNANT LES PAGES QUI SUIVENT

LES PAGES SUIVANTES ONT ÉTÉ REPRODUITES EN DOUBLE AFIN D'AMÉLIORER LA QUALITÉ DE REPRODUCTION

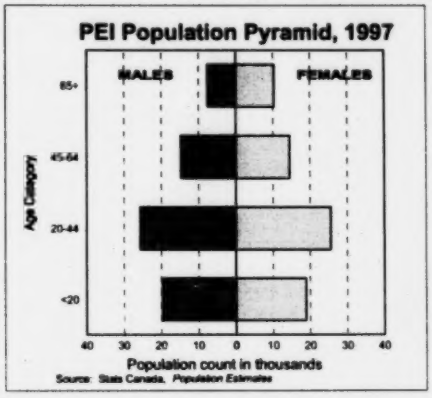
LES UTILISATEURS DOIVENT CONSULTER TOUTES LES PAGES REPRODUITES SUR LA FICHE AFIN D'OBTENIR LA LECTURE DU TEXTE INTÉGRAL

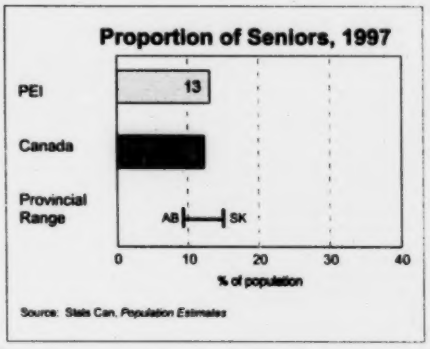
Micromedia
ProQuest

20 Victoria Street
Toronto, Ontario M5C 2N8
Tel.: (416) 362-5211
Toll Free: 1-800-387-2689
Fax: (416) 362-6161
Email: info@micromedia.on.ca

Demographics

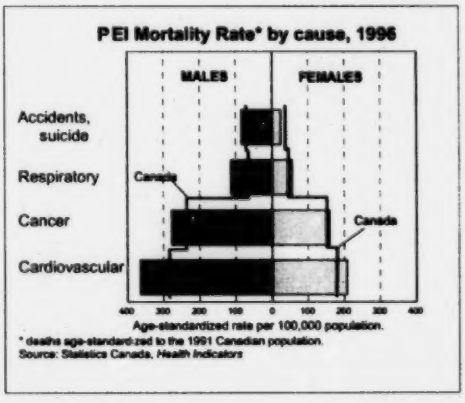
There is little gender variation by age in the Canadian population. While there are more women than men over 65 as a result of women's longer life expectancy, there are virtually equal numbers in all younger age groups. The proportion of the Canadian population age 65 and over increased from 8% in 1971 to 12% in 1996. This aging population has a large influence on health.

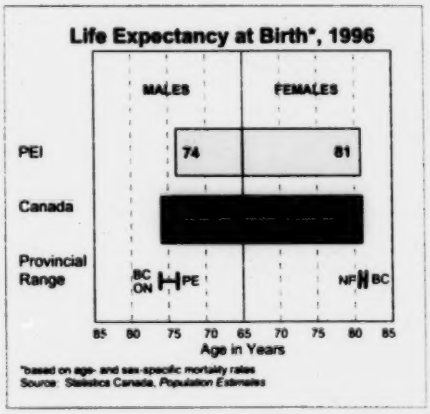




Death

Death is the oldest, most widely used, and most reliable health indicator. Life expectancy has been increasing in Canada and PEI since 1971 when males born could expect to live to age 69, and women to age 77. From 1971 to 1996, the rate of increase for Canadians outpaced the rate for PEI.

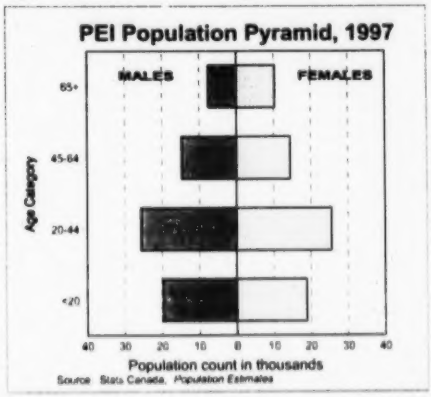


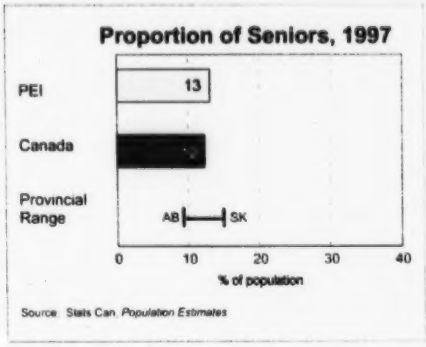


Cardiovascular disease is the leading cause of death. If the emphasis is on the loss of life at an early age, cancer is the leading cause of potential years of life lost (PYLL), closely followed by accidents/suicide. Cancer deaths in PEI are increasing due to increases in lung cancer.

Demographics

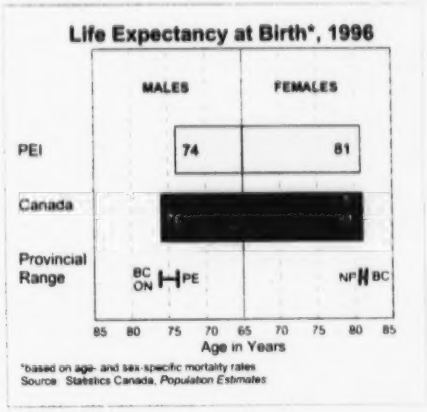
There is little gender variation by age in the Canadian population. While there are more women than men over 65 as a result of women's longer life expectancy, there are virtually equal numbers in all younger age groups. The proportion of the Canadian population age 65 and over increased from 8% in 1971 to 12% in 1996. This aging population has a large influence on health.

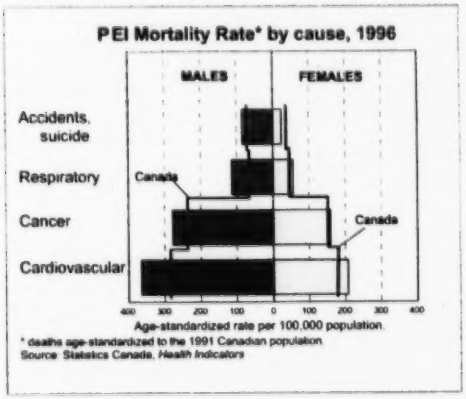




Death

Death is the oldest, most widely used, and most reliable health indicator. Life expectancy has been increasing in Canada and PEI since 1971 when males born could expect to live to age 69, and women to age 77. From 1971 to 1996, the rate of increase for Canadians outpaced the rate for PEI.

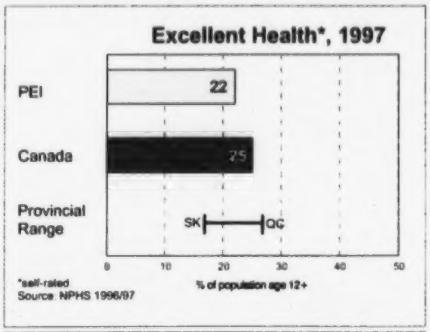




Cardiovascular disease is the leading cause of death. If the emphasis is on the loss of life at an early age, cancer is the leading cause of potential years of life lost (PYLL), closely followed by accidents/suicide. Cancer deaths in PEI are increasing due to increases in lung cancer.

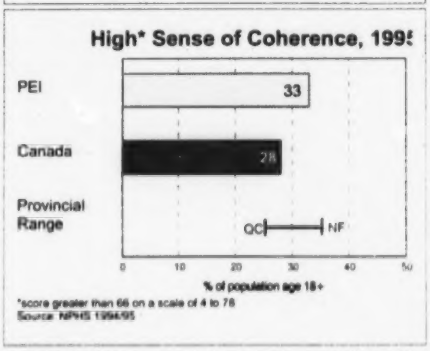
Self-rated Health

Self-rated health summarizes physical and mental health as experienced by the individual according to personal values. 63% of Canadians describe their health as good or excellent. Self-rated health deteriorates with age and low income.



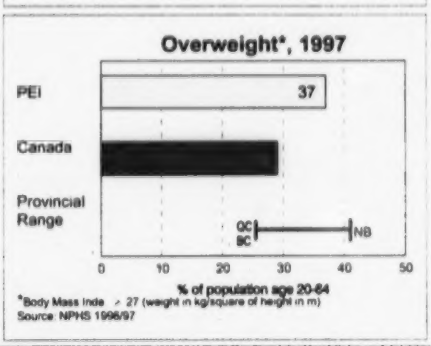
Positive Mental Health

Sense of coherence is a view of the world that events are comprehensible, challenges are manageable, and life is meaningful. This is related to coping successfully with stressors. Unlike most measures of health, sense of coherence increases with age. It does not differ by education or sex.



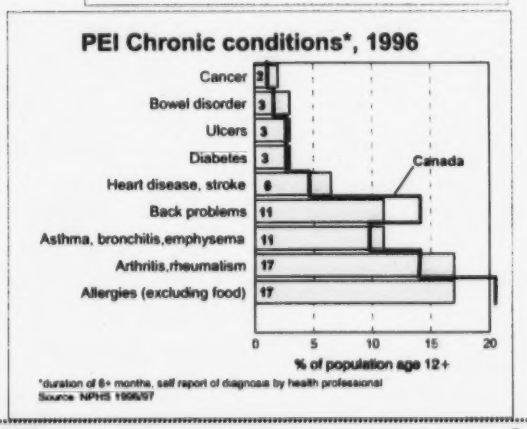
Body Weight

Body weight depends on a combination of factors, including genetics, diet, and active living. Obesity is linked to cardiovascular disease, diabetes, and some cancers. Overweight persons are more likely to be male, older, and have less education.



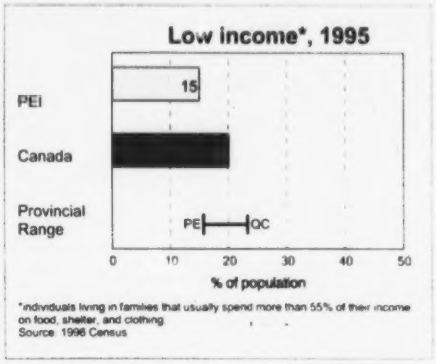
Chronic Conditions

Chronic conditions are major causes of death, potential years of life lost, hospitalization, or affect quality of life. Some, but not all, chronic conditions increase in prevalence with age. Allergies and asthma are most common among the young, and back problems are most common during the working years. The only chronic disease that registers all new cases is cancer.



Income Distribution

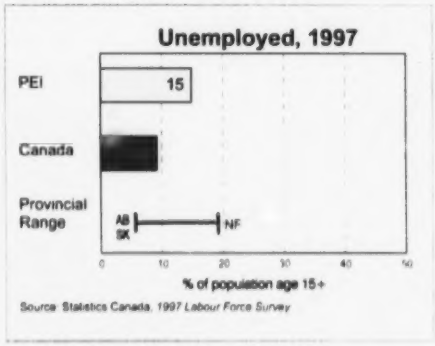
In 1995, the average Canadian income was $25,000 compared to $20,000 in PEI and NF. Overall, men earned more than women in 1995. Between 1990 and 1995, the proportion of Canadians with low-income status increased from 16% to 20%. In PEI the increase was less pronounced from 14% to 15%.



*individuals living in families that usually spend more than 55% of their income on food, shelter, and clothing
Source: 1996 Census

Unemployment Rate

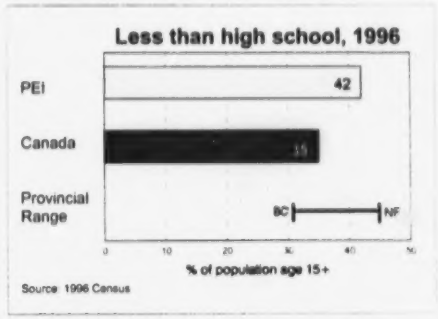
Employment is a measure of the health of a nation's economy. Unemployed people suffer a disproportionate share of health problems, including depression and reduced life expectancy. Unemployment may understate economic impacts on health, since it does not include those too discouraged to seek employment. In 1997, 66% of PEI's population (age 15 and over) were employed or seeking employment, similar to Canada's 65% participation rate. Between 1992 and 1997, PEI's unemployment rate deceased from 18% to 15%.



Source: Statistics Canada, *1997 Labour Force Survey*

Education

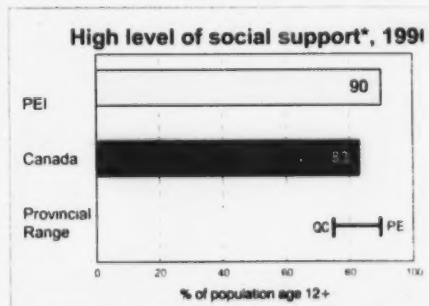
Literacy and numeracy skills are essential for full participation in today's society. People lacking such skills may end up feeling alienated from society and may suffer from various physical and mental health problems. The level of education is related to age: more than twice as many Canadians in their 20's had finished high school compared with people age 55 and older.



Source: 1996 Census

Social Support

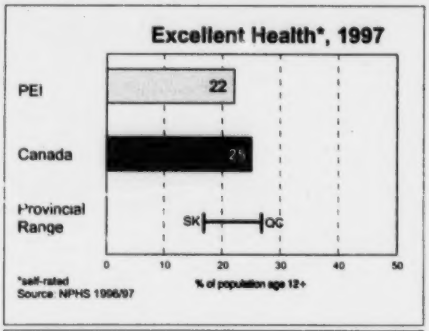
High level of social support is an important coping mechanism for individuals when problems arise. Low level of social support can contribute to depression, suicide, a range of physical conditions and even early death. The only data available on social support are provided, but this scale has not been shown to be reliable, since it does not differentiate between family and non-family social support.



*person with someone to confide in, to count on in a crisis for advice, and to make you feel loved and cared for
Source: NPHS 1996/97

Self-rated Health

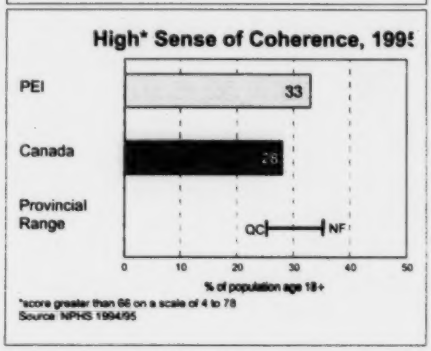
Self-rated health summarizes physical and mental health as experienced by the individual according to personal values. 63% of Canadians describe their health as good or excellent. Self-rated health deteriorates with age and low income.



*self-rated
Source: NPHS 1996/97

Positive Mental Health

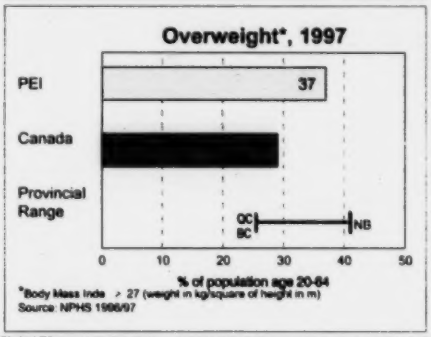
Sense of coherence is a view of the world that events are comprehensible, challenges are manageable, and life is meaningful. This is related to coping successfully with stressors. Unlike most measures of health, sense of coherence increases with age. It does not differ by education or sex.



*score greater than 66 on a scale of 4 to 78
Source: NPHS 1994/95

Body Weight

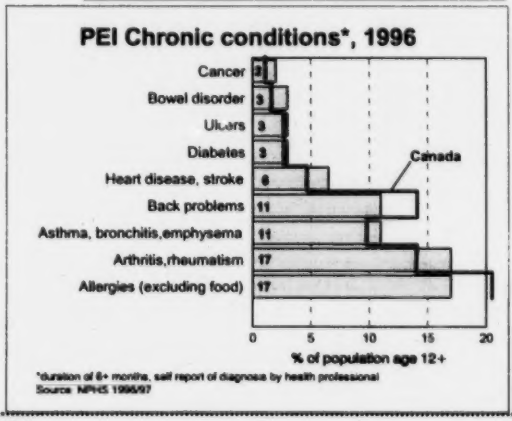
Body weight depends on a combination of factors, including genetics, diet, and active living. Obesity is linked to cardiovascular disease, diabetes, and some cancers. Overweight persons are more likely to be male, older, and have less education.



*Body Mass Inde > 27 (weight in kg/square of height in m)
Source: NPHS 1996/97

Chronic Conditions

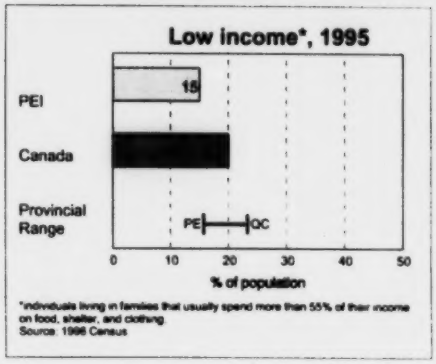
Chronic conditions are major causes of death, potential years of life lost, hospitalization, or affect quality of life. Some, but not all, chronic conditions increase in prevalence with age. Allergies and asthma are most common among the young, and back problems are most common during the working years. The only chronic disease that registers all new cases is cancer.



*duration of 6+ months, self report of diagnosis by health professional
Source: NPHS 1996/97

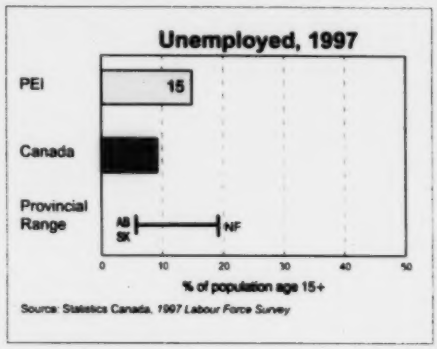
Income Distribution

In 1995, the average Canadian income was $25,000 compared to $20,000 in PEI and NF. Overall, men earned more than women in 1995. Between 1990 and 1995, the proportion of Canadians with low-income status increased from 16% to 20%. In PEI the increase was less pronounced from 14% to 15%.



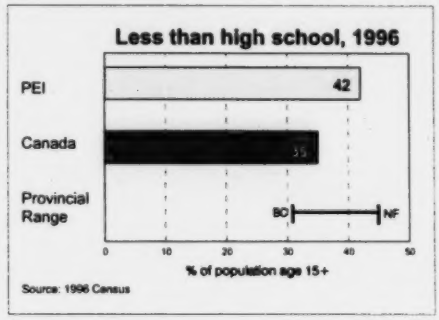
Unemployment Rate

Employment is a measure of the health of a nation's economy. Unemployed people suffer a disproportionate share of health problems, including depression and reduced life expectancy. Unemployment may understate economic impacts on health, since it does not include those too discouraged to seek employment. In 1997, 66% of PEI's population (age 15 and over) were employed or seeking employment, similar to Canada's 65% participation rate. Between 1992 and 1997, PEI's unemployment rate deceased from 18% to 15%.



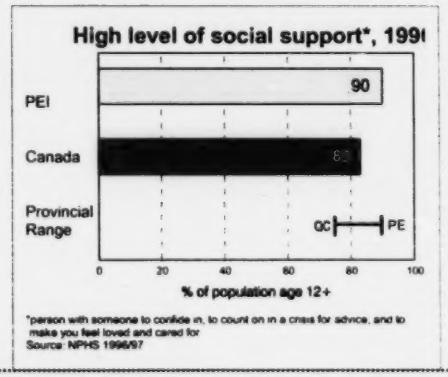
Education

Literacy and numeracy skills are essential for full participation in today's society. People lacking such skills may end up feeling alienated from society and may suffer from various physical and mental health problems. The level of education is related to age: more than twice as many Canadians in their 20's had finished high school compared with people age 55 and older.



Social Support

High level of social support is an important coping mechanism for individuals when problems arise. Low level of social support can contribute to depression, suicide, a range of physical conditions and even early death. The only data available on social support are provided, but this scale has not been shown to be reliable, since it does not differentiate between family and non-family social support.

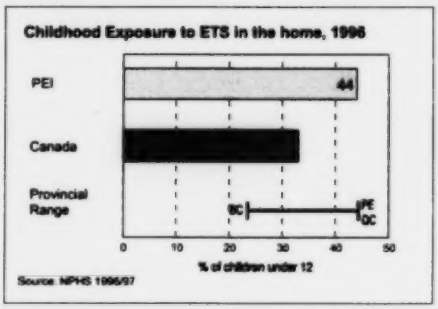


Air Pollution

5 common air pollutants: sulphur dioxide, nitrogen dioxide, ground-level ozone, carbon monoxide, total suspended particulate (airborne particles). Since 1979 the levels of air pollutants have decreased, with the exception of ground-level ozone. The areas most prone to ozone exceeding the national standard are the Windsor-Quebec City corridor, the Lower Fraser Valley (BC), and the Bay of Fundy. Source: Environment Canada, *1999 Canada's National Environmental Indicator Series*

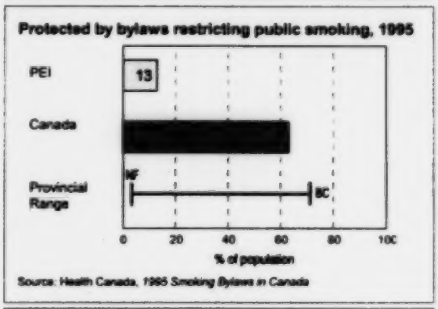
Environmental Tobacco Smoke (ETS)

Young children are particularly susceptible to the effects of ETS, which include complications of pregnancy and low birth weight, sudden infant death syndrome, middle ear infection, asthma, lower respiratory illness, chronic respiratory symptoms, and increased risk of later smoking.



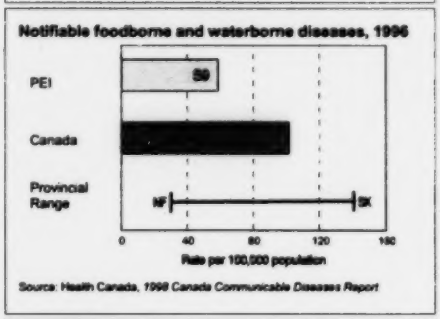
Smoking Restriction Policies

Both smoking and ETS are important and preventable causes of illness and death. Bylaws against smoking in public are almost as effective as tobacco taxes in discouraging the use of cigarettes. PEI showed almost no improvement from 12% of the population covered by bylaws in 1991 to 13% in 1995.



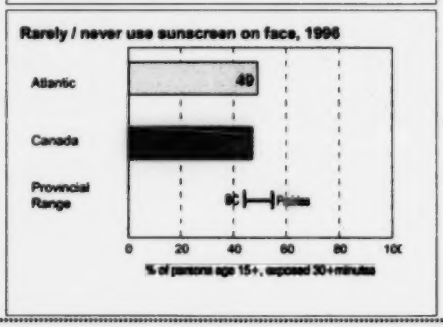
Foodborne and Waterborne Diseases

Enteric symptoms include diarrhea, vomiting, stomach cramps, kidney failure, or death. Enteric infections are the result of eating contaminated food, beverages, or water. Illness can be reduced by good hygiene, correct food storage, and thorough cooking. The enteric diseases that are reportable include: *Campylobacter, Salmonella, Giardia*, and the less common Hepatitis A, *E. coli*, and *Shigella*. As few as 1-10% of cases are reported, since only some patients seek medical care or have specimens taken for laboratory tests.



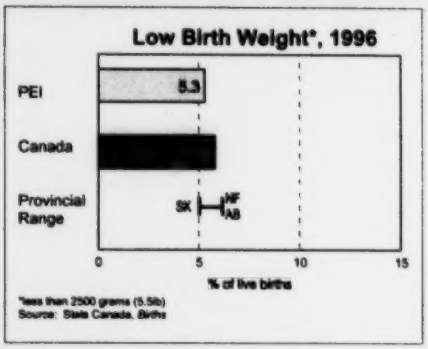
Sun Exposure

Excessive sun exposure can lead to skin cancer, melanoma, and cataracts. Protective measures include sunscreen use, wearing a hat, sunglasses or long-sleeved shirt, avoiding the sun between 11AM and 4PM, or seeking shade. 80% of Canadians are exposed more than 30 minutes daily in the summer. Less than half of Canadians regularly use the easiest protection of wearing a hat or sunscreen on the face.



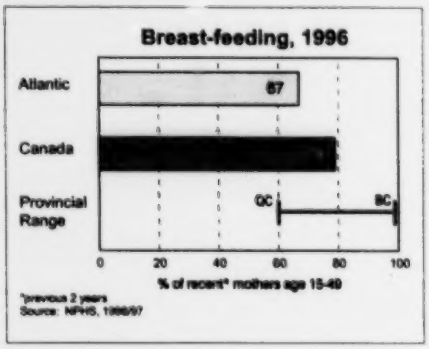
Underweight Births

Low birth weights can result in mental and physical disabilities, or even death. Over half of low birth weights are due to premature birth; the rest are due to lack of prenatal nourishment, maternal hypertension, or maternal smoking. Low birth weights are common among mothers under 15 and over 45.



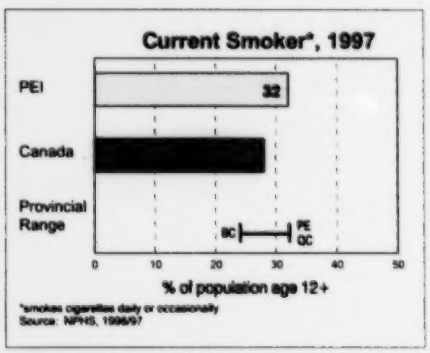
Breast-feeding

Breast milk is recommended as the only source of nutrients for most infants in the first 3-6 months of life. The current breast feeding rate in the Atlantic provinces is similar to the Canadian rate 15 years ago. Breast feeding is most common among mothers over 25, and mothers with higher education.



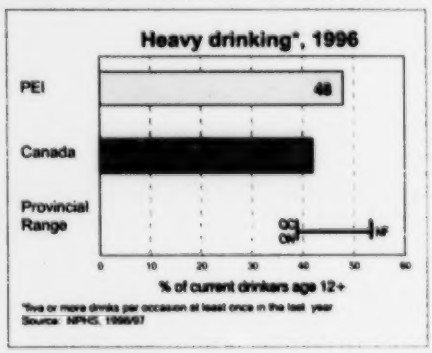
Smoking

Smoking is the most important preventable cause of death. Health effects include low birth weight, sudden infant death syndrome, asthma, bronchitis, emphysema, lung cancer, stroke, heart disease. In spite of this, PEI males have the highest smoking rate(41%), followed by Quebec (38%). The good news is that PEI student smoking rates have recently decreased, while across Canada, these rates are increasing.



Problem Drinking

Excessive use of alcohol can lead to health and social problems. Men are more likely than women to report heavy drinking on a regular basis. Binge drinking is most common among youth (under 25), and decreases with education.

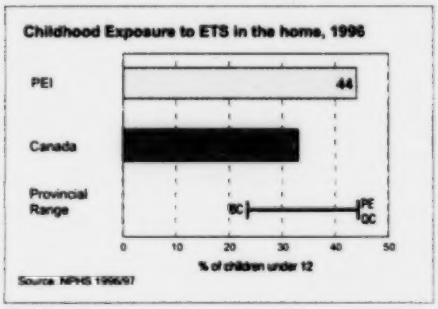


Air Pollution

5 common air pollutants: sulphur dioxide, nitrogen dioxide, ground-level ozone, carbon monoxide, total suspended particulate (airborne particles). Since 1979 the levels of air pollutants have decreased, with the exception of ground-level ozone. The areas most prone to ozone exceeding the national standard are the Windsor-Quebec City corridor, the Lower Fraser Valley (BC), and the Bay of Fundy. Source: Environment Canada, *1999 Canada's National Environmental Indicator Series*

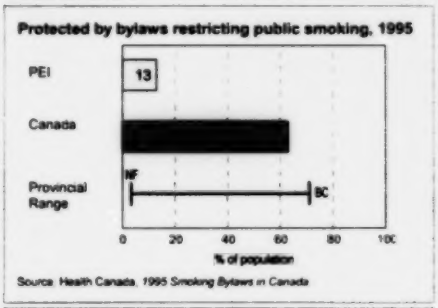
Environmental Tobacco Smoke (ETS)

Young children are particularly susceptible to the effects of ETS, which include complications of pregnancy and low birth weight, sudden infant death syndrome, middle ear infection, asthma, lower respiratory illness, chronic respiratory symptoms, and increased risk of later smoking.



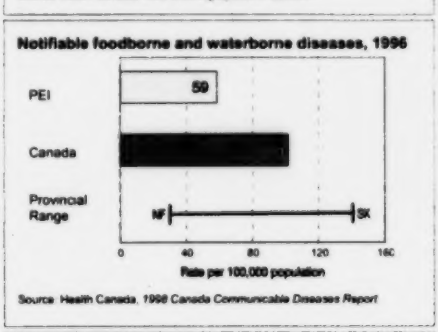
Smoking Restriction Policies

Both smoking and ETS are important and preventable causes of illness and death. Bylaws against smoking in public are almost as effective as tobacco taxes in discouraging the use of cigarettes. PEI showed almost no improvement from 12% of the population covered by bylaws in 1991 to 13% in 1995.



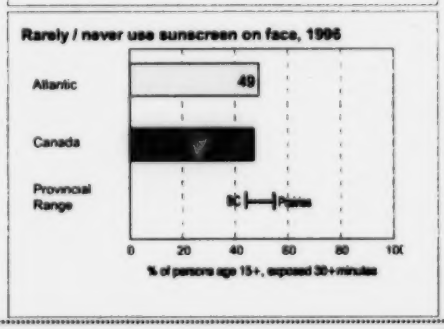
Foodborne and Waterborne Diseases

Enteric symptoms include diarrhea, vomiting, stomach cramps, kidney failure, or death. Enteric infections are the result of eating contaminated food, beverages, or water. Illness can be reduced by good hygiene, correct food storage, and thorough cooking. The enteric diseases that are reportable include: *Campylobacter, Salmonella, Giardia*, and the less common Hepatitis A, *E. coli*, and *Shigella*. As few as 1-10% of cases are reported, since only some patients seek medical care or have specimens taken for laboratory tests.

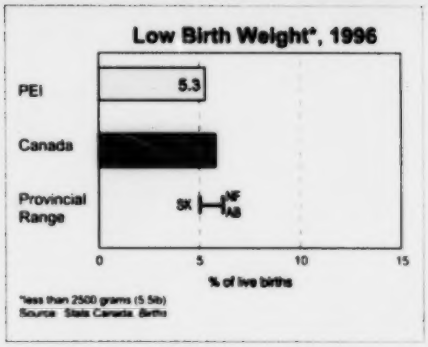


Sun Exposure

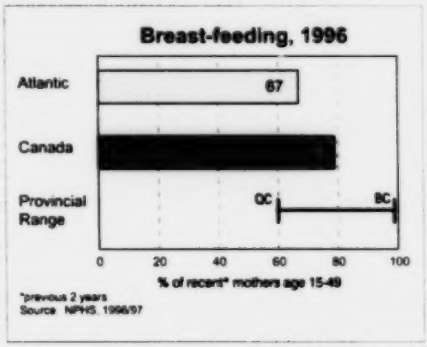
Excessive sun exposure can lead to skin cancer, melanoma, and cataracts. Protective measures include sunscreen use, wearing a hat, sunglasses or long-sleeved shirt, avoiding the sun between 11AM and 4PM, or seeking shade. 80% of Canadians are exposed more than 30 minutes daily in the summer. Less than half of Canadians regularly use the easiest protection of wearing a hat or sunscreen on the face.



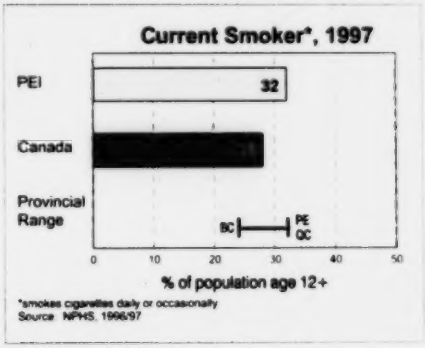
Underweight Births
Low birth weights can result in mental and physical disabilities, or even death. Over half of low birth weights are due to premature birth; the rest are due to lack of prenatal nourishment, maternal hypertension, or maternal smoking. Low birth weights are common among mothers under 15 and over 45.



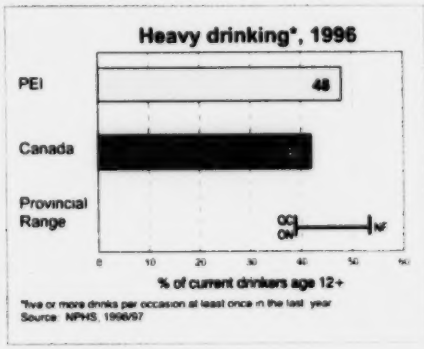
Breast-feeding
Breast milk is recommended as the only source of nutrients for most infants in the first 3-6 months of life. The current breast feeding rate in the Atlantic provinces is similar to the Canadian rate 15 years ago. Breast feeding is most common among mothers over 25, and mothers with higher education.



Smoking
Smoking is the most important preventable cause of death. Health effects include low birth weight, sudden infant death syndrome, asthma, bronchitis, emphysema, lung cancer, stroke, heart disease. In spite of this, PEI males have the highest smoking rate(41%), followed by Quebec (38%). The good news is that PEI student smoking rates have recently decreased, while across Canada, these rates are increasing.

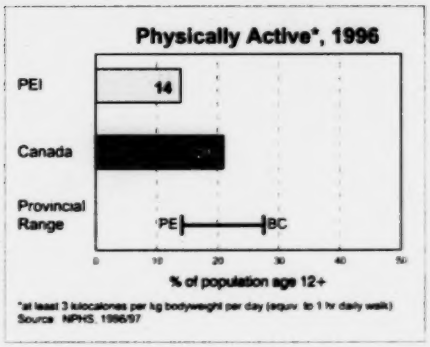


Problem Drinking
Excessive use of alcohol can lead to health and social problems. Men are more likely than women to report heavy drinking on a regular basis. Binge drinking is most common among youth (under 25), and decreases with education.



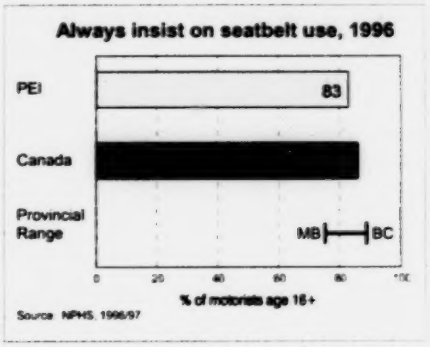
Physical Activity

Physical activity reduces the risk of heart disease, diabetes, cancer, osteoporosis, as well as weight control and stress reduction. Males are more active than females. Two-thirds of youth aged 5-17 are not active enough for optimal growth and development. As Canadians age they become more sedentary (except ages 65-74). Activity levels increase with education and income.



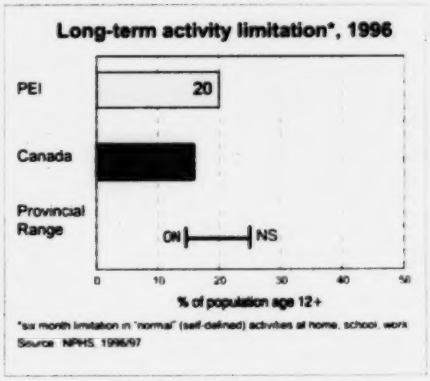
Seatbelt Use

Seatbelts are mandatory in all provinces, to reduce motor vehicle fatalities. Prior to legislation, only 15% to 30% of motorists wore seatbelts. Seatbelt use does not differ by education level.



Long-term Activity Limitation

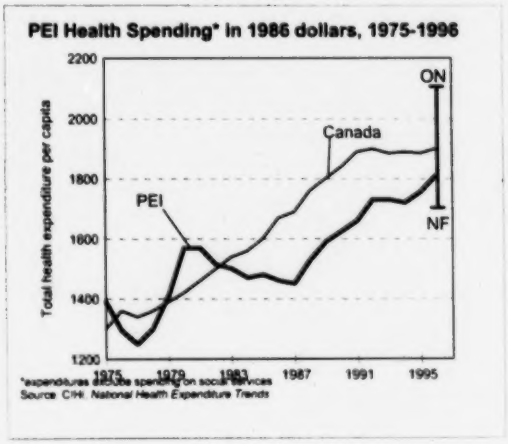
Limitation of activity measures the impact of *all* health problems experienced in the past year. It provides a personal perspective on the importance and effect of health problems. The main cause of disability was back problems, and vision or hearing difficulties. Other causes include musculoskeletal problems, respiratory conditions, and heart conditions. Limitations increase with age.



Reporting on service delivery is fraught with difficulties. Data collection is primarily hospital based, while the health system is increasingly community-based. Self-report data do not match service delivery data. Data collected in different regions is not always comparable.

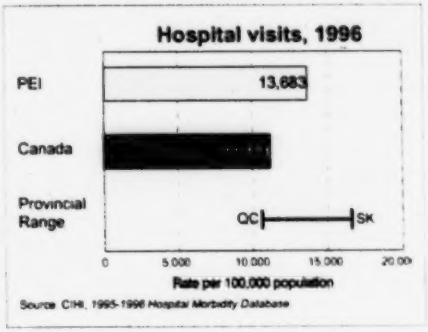
Health Expenditures

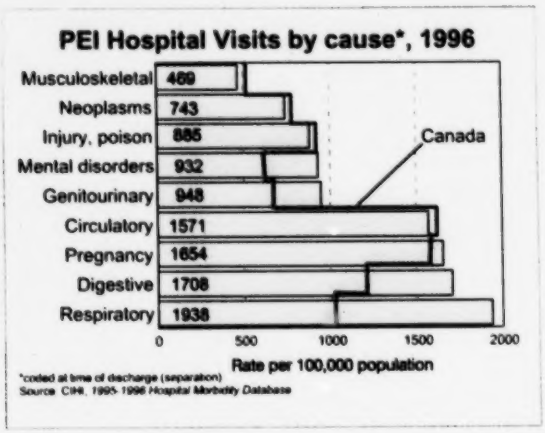
Increases in health expenditures are a result of a combination of population growth, increased utilization per capita, or increased prices.
In 1996, PEI health spending was $2,467 (in 1996 dollars) per person for: hospitals (37%), drugs (16%), other institutions (14%), physicians(10%), and other professionals, administration, public health, home care, etc.
70% of health expenses are public, and the 30% of private spending is mostly for drugs, dental, and vision care.



Hospitalization

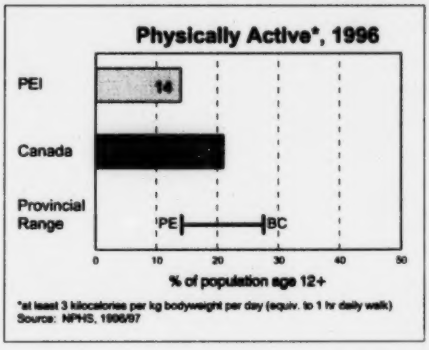
Hospitalization rates and length of stay increase with age. There are striking interprovincial differences in hospital visits. Respiratory disease, digestive disease, and circulatory hospitalizations were highest in SK and NB. Hospitalizations for pregnancy and childbirth were highest in MB.





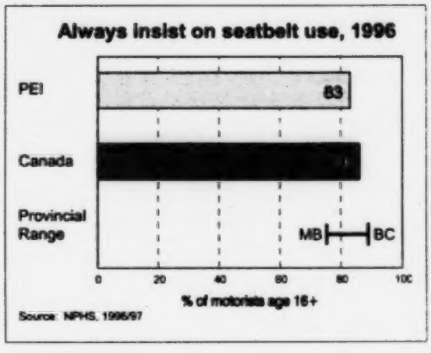
Physical Activity

Physical activity reduces the risk of heart disease, diabetes, cancer, osteoporosis, as well as weight control and stress reduction. Males are more active than females. Two-thirds of youth aged 5-17 are not active enough for optimal growth and development. As Canadians age they become more sedentary (except ages 65-74). Activity levels increase with education and income.



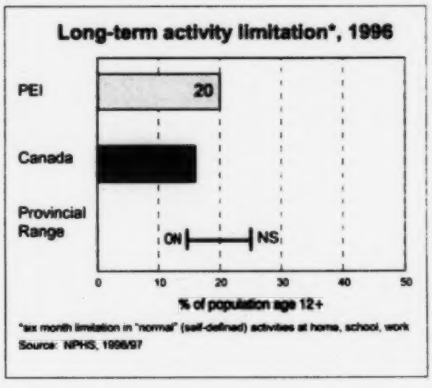
Seatbelt Use

Seatbelts are mandatory in all provinces, to reduce motor vehicle fatalities. Prior to legislation, only 15% to 30% of motorists wore seatbelts. Seatbelt use does not differ by education level.



Long-term Activity Limitation

Limitation of activity measures the impact of *all* health problems experienced in the past year. It provides a personal perspective on the importance and effect of health problems. The main cause of disability was back problems, and vision or hearing difficulties. Other causes include musculoskeletal problems, respiratory conditions, and heart conditions. Limitations increase with age.



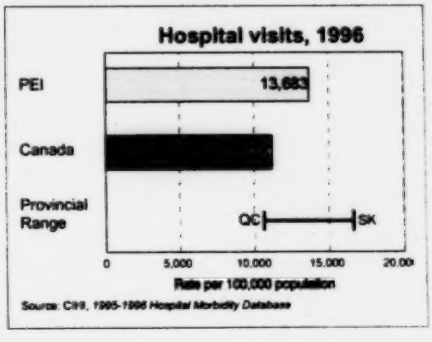
Reporting on service delivery is fraught with difficulties. Data collection is primarily hospital based, while the health system is increasingly community-based. Self-report data do not match service delivery data. Data collected in different regions is not always comparable.

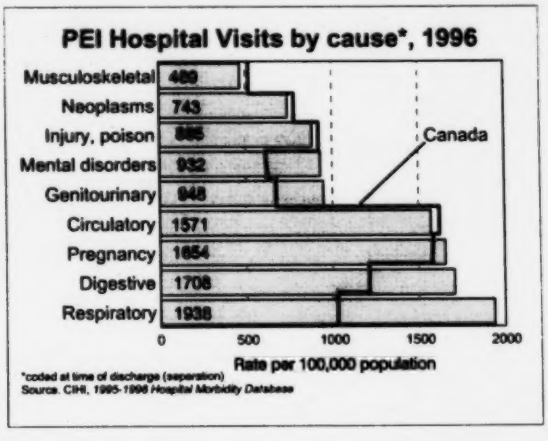
Health Expenditures

Increases in health expenditures are a result of a combination of population growth, increased utilization per capita, or increased prices.
In 1996, PEI health spending was $2,467 (in 1996 dollars) per person for: hospitals (37%), drugs (16%), other institutions (14%), physicians(10%), and other professionals, administration, public health, home care, etc.
70% of health expenses are public, and the 30% of private spending is mostly for drugs, dental, and vision care.

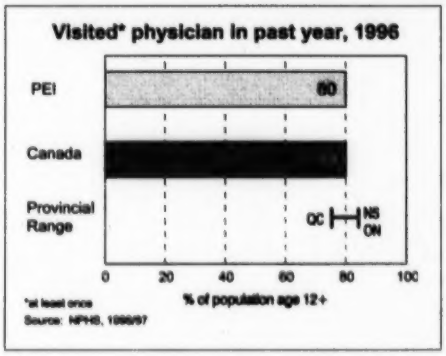
Hospitalization

Hospitalization rates and length of stay increase with age. There are striking interprovincial differences in hospital visits. Respiratory disease, digestive disease, and circulatory hospitalizations were highest in SK and NB. Hospitalizations for pregnancy and childbirth were highest in MB.

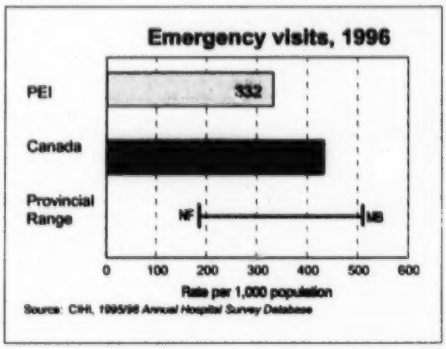




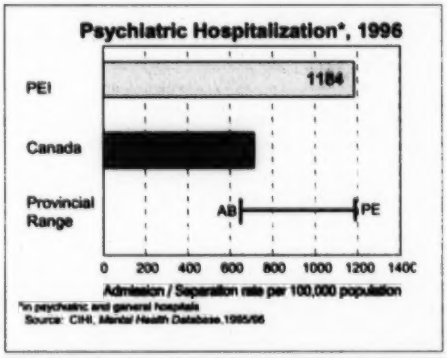
Physician Visits
Women were more likely than men to report multiple visits to a physician in the past year, especially women aged 20 to 44. Physician visits increase with age for both men and women.



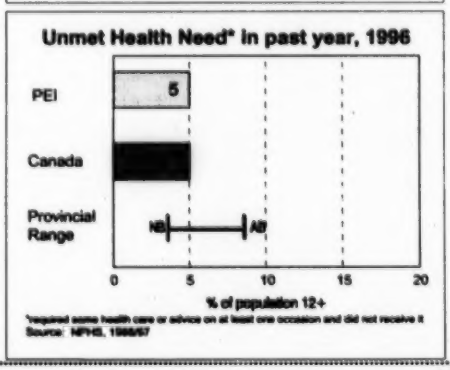
Emergency Visits
In Canada, there has been a 31% decline in visits to emergency departments between 1991 and 1996. This may be partly attributable to the closing of hospital emergency departments, the opening of community walk-in clinics and urgent care centres, as well as the triaging of patients to appropriate services.



Psychiatric Hospitalization
In Canada, treatment for mental disorders is showing a decline in admissions at the same time as an increase in patient-days. This suggests that less serious cases are increasingly being treated in the community, while more severe and persistent cases require hospitalization. However, PEI has not seen a decline in psychiatric admissions and has the shortest length of stay. The most common reason for psychiatric hospitalization in PEI is depression.



Unmet Health Needs
"Universality" means that all citizens will have access to the care they need within a reasonable period of time. However, since there is no accepted definition of "care needed", some persons may perceive they have unmet health care needs. There was no difference by age, sex, or education. Most unmet needs were for physical health conditions, followed by emotional health and injuries.

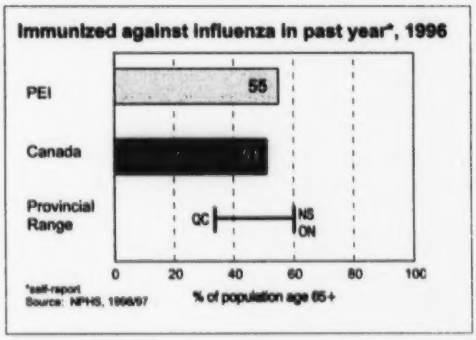


HEALTH SERVICES

Access to proven cost-effective services is not always consistent, or uniformly available.

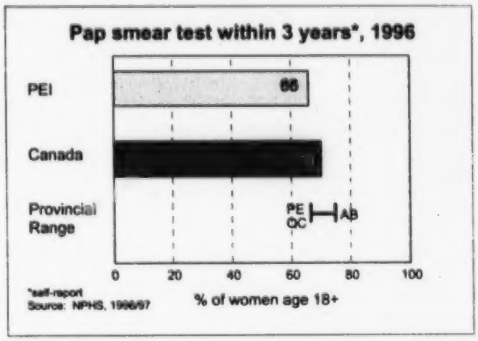
Flu Vaccine

Immunization recommended annually for seniors and immuno-compromised, to lessen the severity of influenza.



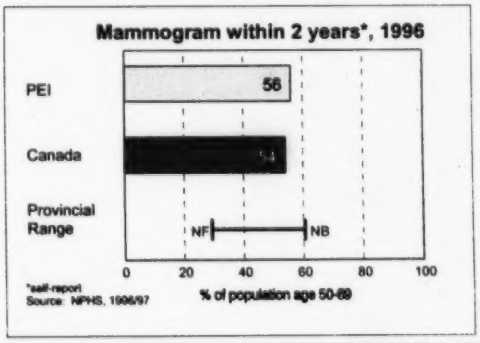
Pap Smears

Pap smears are recommended every 3 years for women aged 18 to 69, to prevent cervical cancer.



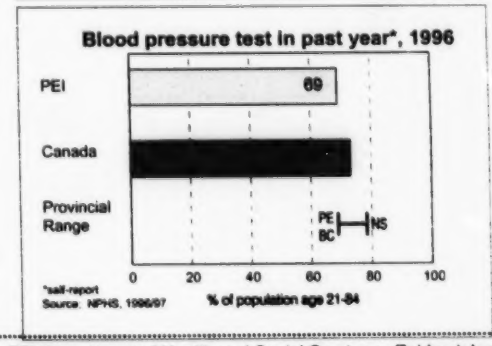
Screening Mammogram

Mammograms recommended every 2 years for women aged 50 to 69, for early detection of breast cancer. The most common reason for not having a recent mammogram was that they didn't think it was necessary. Other reasons were that they had not got around to it, their doctor said it was not necessary, or they were afraid/embarrassed to get the test.



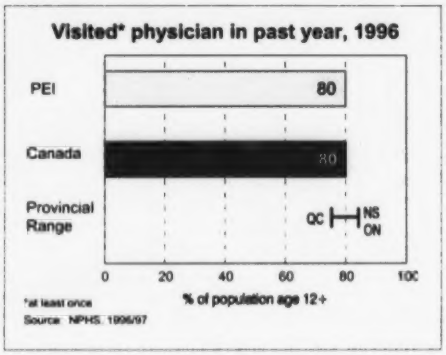
Blood Pressure

Measurement of blood pressure during a medical visit is recommended for persons aged 21 to 84, to detect hypertension.



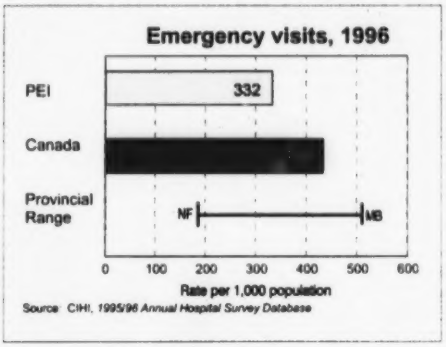
Physician Visits

Women were more likely than men to report multiple visits to a physician in the past year, especially women aged 20 to 44. Physician visits increase with age for both men and women.



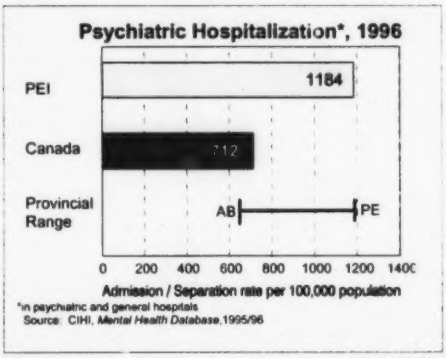
Emergency Visits

In Canada, there has been a 31% decline in visits to emergency departments between 1991 and 1996. This may be partly attributable to the closing of hospital emergency departments, the opening of community walk-in clinics and urgent care centres, as well as the triaging of patients to appropriate services.



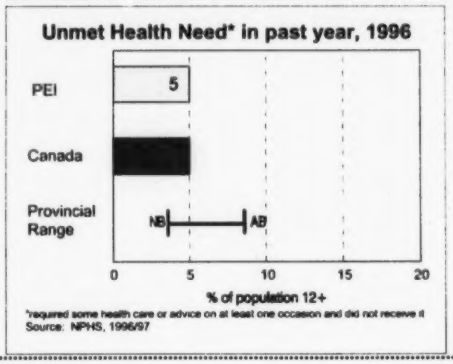
Psychiatric Hospitalization

In Canada, treatment for mental disorders is showing a decline in admissions at the same time as an increase in patient-days. This suggests that less serious cases are increasingly being treated in the community, while more severe and persistent cases require hospitalization. However, PEI has not seen a decline in psychiatric admissions and has the shortest length of stay. The most common reason for psychiatric hospitalization in PEI is depression.



Unmet Health Needs

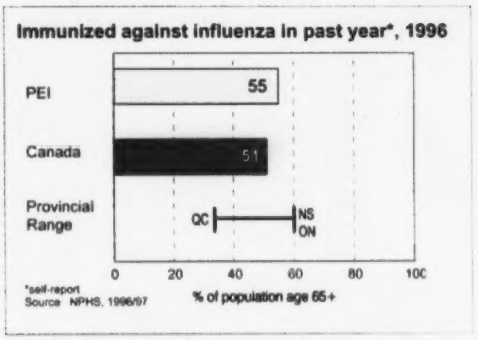
"Universality" means that all citizens will have access to the care they need within a reasonable period of time. However, since there is no accepted definition of "care needed", some persons may perceive they have unmet health care needs. There was no difference by age, sex, or education. Most unmet needs were for physical health conditions, followed by emotional health and injuries.



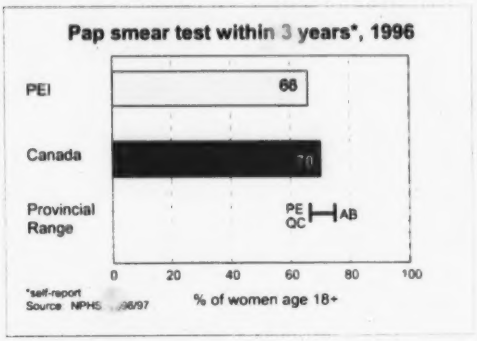
HEALTH SERVICES

Access to proven cost-effective services is not always consistent, or uniformly available.

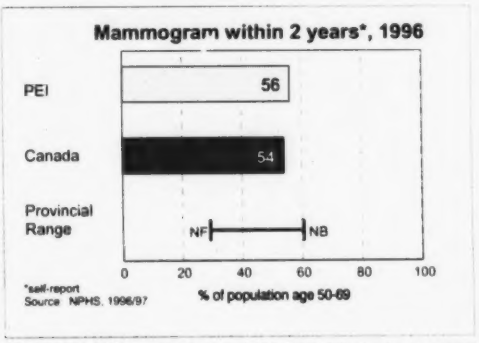
Flu Vaccine
Immunization recommended annually for seniors and immuno-compromised, to lessen the severity of influenza.



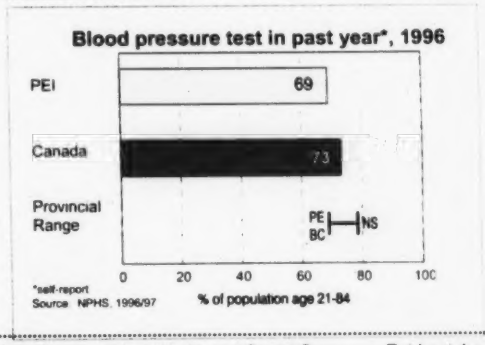
Pap Smears
Pap smears are recommended every 3 years for women aged 18 to 69, to prevent cervical cancer.



Screening Mammogram
Mammograms recommended every 2 years for women aged 50 to 69, for early detection of breast cancer. The most common reason for not having a recent mammogram was that they didn't think it was necessary. Other reasons were that they had not got around to it, their doctor said it was not necessary, or they were afraid/embarrassed to get the test.

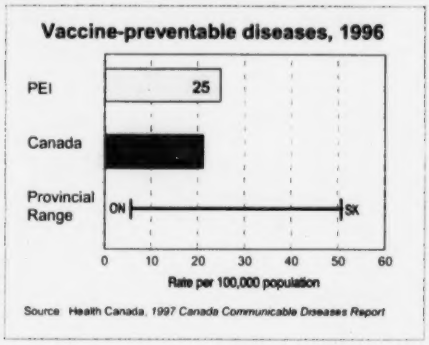


Blood Pressure
Measurement of blood pressure during a medical visit is recommended for persons aged 21 to 84, to detect hypertension.



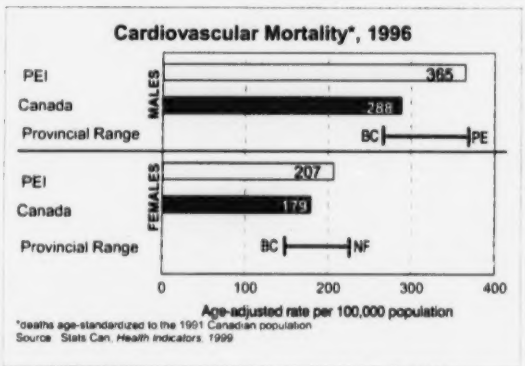
Vaccine Preventable Diseases

Many childhood and adult diseases are prevented by vaccination. Canada was officially certified polio-free in 1994. Diptheria, tetanus, and *Haemophilus influenza* type b have a few cases reported per year. Rubella, mumps, and measles each are reported at about 1 case per 100,000 in Canada. The most common vaccine-preventable disease is pertussis (whooping cough) at 18 cases per 100,000 population.



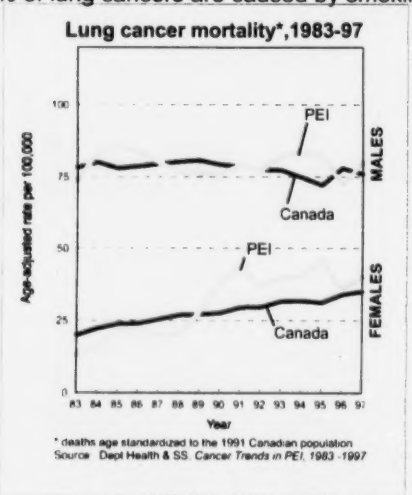
Cardiovascular Death

Cardiovascular disease (ischemic heart disease and stroke) is the major cause of death. Cardiovascular deaths can be prevented by smoking cessation, reduction in dietary fat, more exercise, improved identification and control of high blood pressure, as well as medical and surgical interventions.



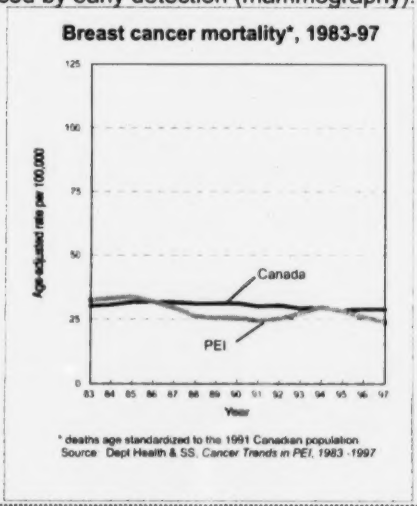
Lung Cancer Death

Lung cancer is the most common cause of cancer deaths in both men and women. 90% of lung cancers are caused by smoking.



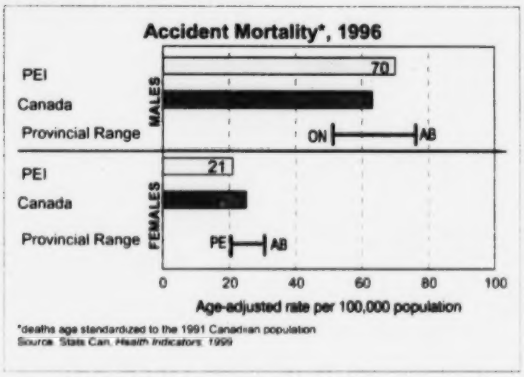
Breast Cancer Death

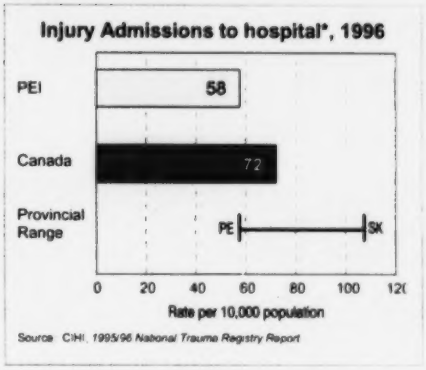
Breast cancer is the most common form of new cancer cases in women. This disease can be reduced by early detection (mammography).



Hospitalization due to Trauma

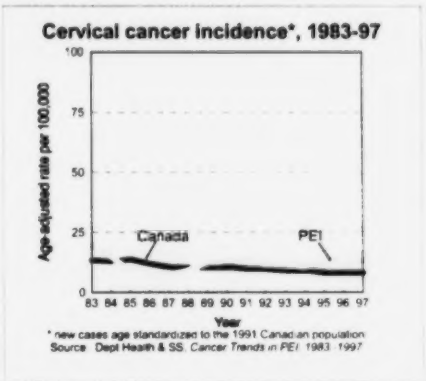
90% of injuries are preventable. Injuries are the leading cause of death between ages 1 and 44, and are a serious cause of disability. Admissions are most common among seniors and caused by unintentional falls. The leading cause of injury for 15-34 year olds was motor vehicle collisions.





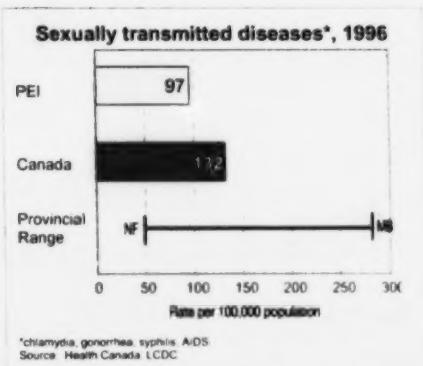
Cervical Cancer Incidence

Over 90% of new cervical cancer cases can be prevented by regular pap screening. The rate of new cases is decreasing in Canada, although this trend is not apparent in PEI.



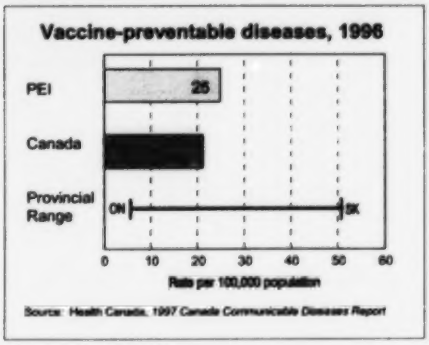
Sexually Transmitted Diseases

Unprotected sexually activity can spread infection with STDs. Chlamydia (the most common STD) and gonorrhea can result in infertility in both sexes. Syphilis can damage the brain. AIDS can result in death. The prevalence of viral STDs (HIV, human papillovirus, genital herpes, hepatitis B) is not recorded.



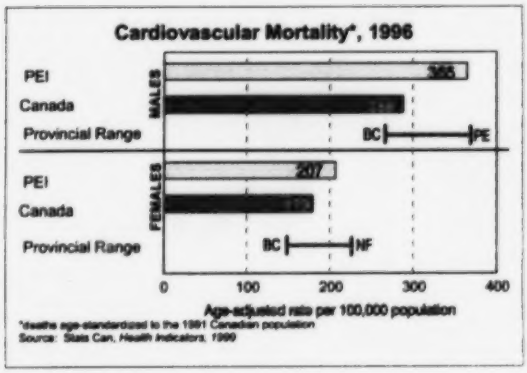
Vaccine Preventable Diseases

Many childhood and adult diseases are prevented by vaccination. Canada was officially certified polio-free in 1994. Diptheria, tetanus, and *Haemophilus influenza* type b have a few cases reported per year. Rubella, mumps, and measles each are reported at about 1 case per 100,000 in Canada. The most common vaccine-preventable disease is pertussis (whooping cough) at 18 cases per 100,000 population.



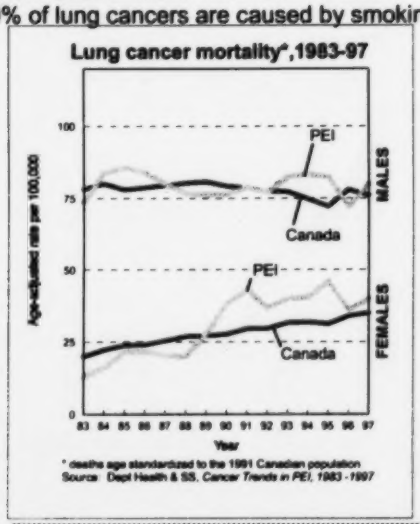
Cardiovascular Death

Cardiovascular disease (ischemic heart disease and stroke) is the major cause of death. Cardiovascular deaths can be prevented by smoking cessation, reduction in dietary fat, more exercise, improved identification and control of high blood pressure, as well as medical and surgical interventions.



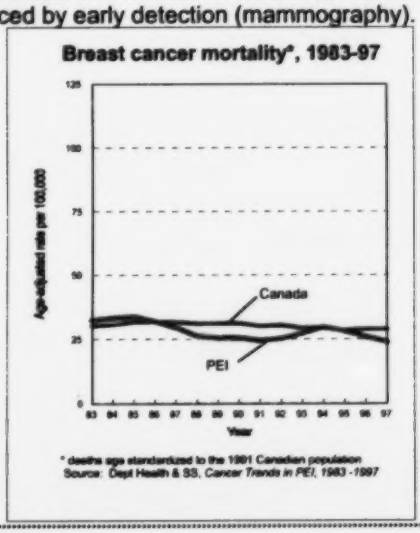
Lung Cancer Death

Lung cancer is the most common cause of cancer deaths in both men and women. 90% of lung cancers are caused by smoking.



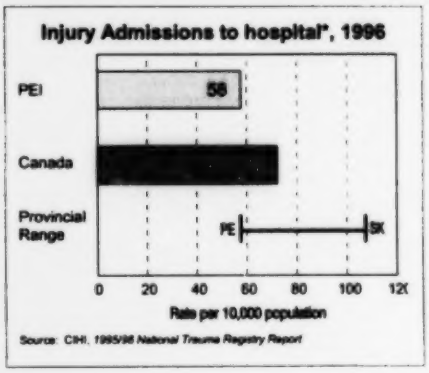
Breast Cancer Death

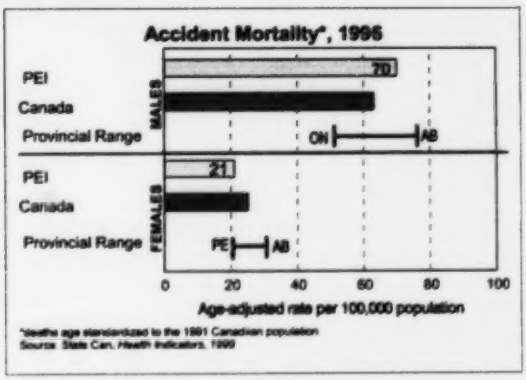
Breast cancer is the most common form of new cancer cases in women. This disease can be reduced by early detection (mammography).



Hospitalization due to Trauma

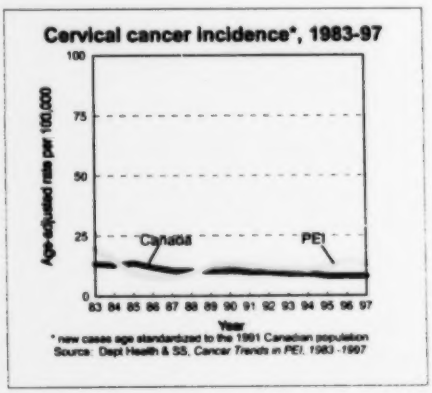
90% of injuries are preventable. Injuries are the leading cause of death between ages 1 and 44, and are a serious cause of disability. Admissions are most common among seniors and caused by unintentional falls. The leading cause of injury for 15-34 year olds was motor vehicle collisions.





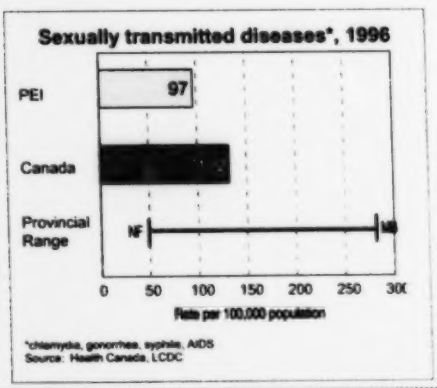
Cervical Cancer Incidence

Over 90% of new cervical cancer cases can be prevented by regular pap screening. The rate of new cases is decreasing in Canada, although this trend is not apparent in PEI.


Cervical cancer incidence*, 1983-97
Age-adjusted rate per 100,000
100
75
50
25
0
Canada
PEI
83 84 85 86 87 88 89 90 91 92 93 94 95 96 97
Year
* new cases age standardized to the 1991 Canadian population
Source: Dept Health & SS, Cancer Trends in PEI, 1983 -1997

Sexually Transmitted Diseases

Unprotected sexually activity can spread infection with STDs. Chlamydia (the most common STD) and gonorrhea can result in infertility in both sexes. Syphilis can damage the brain. AIDS can result in death. The prevalence of viral STDs (HIV, human papillovirus, genital herpes, hepatitis B) is not recorded.



Summary

The 1999 *Second Report on the Health of Canadians* details many measures of health and health determinants. Comments on the nation's health are based on the most current information available. It is a tool to alert policy makers, practitioners and the public to current and future challenges in health. For PEI, the report has some good news and bad news.

On the positive side, Islanders have a high measure of positive mental health, and the highest level of social support in Canada. PEI's income distribution is one of the most equitable in Canada, air quality is good, and sexually transmitted disease rates are low. Compared to the Canadian average, PEI women have higher rates of mammography screening, and have a corresponding lower rate of breast cancer. PEI seniors are more likely than other Canadians to be immunized against influenza. PEI as well as Canada have experienced success stories with seat belt use, and most vaccine-preventable diseases.

When optimal conditions for a child's development are provided, the child experiences positive outcomes for a lifetime. Many Island children start well since PEI has a low rate of underweight births. However, Atlantic Canada has one of the lowest breast feeding rates across the country. PEI children are the most likely to be exposed to second-hand smoke in their home, and Islanders are less likely to be protected by smoking restriction bylaws (compared to other Canadians).

PEI's population includes 13% seniors, compared to 12% in Canada. The aging of PEI's population contributes to our higher rates arthritis and long-term activity limitations (compared to other Canadians). Age also partially explains the lower personal perception of health of Islanders (compared to other Canadians). The health of Islanders is also affected by our high level of unemployment, high alcohol consumption, and low level of education.

Several other issues are identified as areas of concern. PEI has high rates for asthma and other respiratory diseases. PEI women have the lowest rate of pap smear screening in Canada, and have a corresponding higher rate of cervical cancer.
PEI's most general measure of health, life expectancy, is the lowest in Canada, especially for PEI males. This is a predictable result of the highest male smoking rate in Canada, the lowest rate of physical activity in Canada, and the lowest rate of blood pressure testing in Canada. The consequence is the highest rate of cardiovascular deaths in Canada, as well as one of the highest lung cancer mortality rates.

Sources

This report contains PEI highlights of the 220 page report :

- Toward a Healthy Future:
  Second Report on the Health of Canadians
  Prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health for the meeting of Ministers of Health, Charlottetown, PEI, September 1999

The report and its larger companion "Statistical Report on the Health of Canadians" are available at web site: www.hc-sc.gc.ca

Major information sources for the data:

- NPHS
  National Population Health Survey is a longitudinal household-based survey conducted every two years by Statistics Canada. Personal interviews cover a variety of health topics. 20,000 Canadians age 15 and over were surveyed in 94/95 and 96/97. This includes 900 Prince Edward Islanders. Persons living in institutions, on Indian reserves, or on Canadian Forces Bases are not represented. Response rates for both NPHS cycles were over 85%. Estimates calculated from NPHS data are accurate within 1 or 2 percentage points, 19 times out of 20.

- 1996 Census
  Census and other Stat Can statistics available at web site: www.statcan.ca

- Canadian Institute for Health Information
  more info available at web site: www.cihi.ca

- "Canadian Guide to Clinical Preventative Health Care"
  Canadian Task Force on the Periodic Health Examination
  Health Canada, 1994.

- "Smoking in Prince Edward Island" Smoking Fact Sheet
  PEI Department of Health and Social Services - Epidemiology Unit; May 1999.

- "Prince Edward Island 1998 Student Drug Survey, Highlights Report"
  L Van Til, H MacMillan, C Poulin
  PEI Queen's Printer; November 1998.

- "Cancer Trends in Prince Edward Island, 1983-1997"
  LD Van Til, D Dryer
  PEI Department of Health and Social Services - Epidemiology Unit; Dec 1997.